

For the fastest processing, submit claims electronically through our **Dental Office Toolkit!**
It's free, easy, and available to all dentists. Check our Web sites for more information.

INSTRUCTIONS FOR COMPLETING THE SCANNABLE CLAIM

Optical scanning of paper claims can decrease total processing time by two to three days over those claims that must be manually keyed.

FOR CLAIMS TO BE OPTICALLY SCANNED:

- Clearly type, hand write, or use a computer printer to enter information.
- Use all upper-case (capital) letters, if possible.
- Write, type, or print in black or blue pen/ink—do not use red or green ink or any color of highlighter.
- Keep information within the correct field.
- Make sure the typewriter or printer ribbon is dark and the print can be easily read.
- Cover mistakes with line tape and print or type over—do not use liquid correction fluid.
- Use paperclips to hold attachments whenever possible. Place stapled items only at the lower edge of the form.

FIELDS 2 THROUGH 21—PATIENT/SUBSCRIBER INFORMATION:

- If the patient has dental coverage through another carrier(s), complete the other coverage section, fields #2 through #10 (if not, leave them blank). Fill in the amount of primary payment (#3) ONLY when the claim is billing for secondary benefits. Do not enter \$0 unless the primary carrier's determination of payment was \$0. DO NOT ATTACH the primary carrier's voucher.
- Enter the patient's and subscriber's names in this order: last, first, middle initial. Do not use titles, such as Mrs. or Dr.

FIELDS 22 THROUGH 31—DENTAL SERVICES AND REMARKS:

- Hand or machine print
- When machine printing, double-space lines and enter information in between the correct column guidelines. Dates may be entered without separators (/).
- Use current ADA CDT procedure codes.
- Use the REMARKS section (#31) for information necessary to process the claim, such as non-standard COB, miscellaneous codes, codes for which Delta Dental requires a report, or supporting documentation that will assist in accurately processing the claim. Keep documentation within the designated field. Unnecessary documentation delays processing.

FIELDS 39 THROUGH 51—BILLING DENTIST AND TREATING DENTIST:

- The dentist's name or business name entered in field #39 must match the name on file with Delta Dental.
- Enter the license number and Tax Identification number (TIN) of the treating dentist in fields #46 and #47. Enter his/her National Provider Identifier (NPI) in field #45.
- Fields #40 through #43 are optional for group practices or practices with more than one location who have more than one NPI, license number and/or TIN.

NOTICE TO ALL PARTIES COMPLETING THIS FORM:

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

MAIL CLAIMS TO:	MAIL INQUIRIES TO:	TELEPHONE FOR ELIGIBILITY AND BENEFIT INFO
Delta Dental P.O. Box 9085 Farmington Hills, MI 48333-9085	Delta Dental Attn: Customer Service P.O. Box 9089 Farmington Hills, MI 48333-9089	800-524-0149

Delta Dental of Michigan
www.deltadentalmi.com

Delta Dental of Ohio
www.deltadentaloh.com

Delta Dental of Indiana
www.deltadentalin.com

Delta Dental of North Carolina
www.deltadentalnc.com

DENTAL CLAIM STATEMENT

TYPE OF TRANSACTION		SUBSCRIBER INFORMATION																											
1. <input type="checkbox"/> STATEMENT OF ACTUAL SERVICES <input type="checkbox"/> PRE-TREATMENT ESTIMATE		11. SUBSCRIBER NAME (LAST, FIRST, MIDDLE INITIAL), ADDRESS, CITY, STATE, ZIP																											
<div style="display: flex; align-items: center;"> <div style="background-color: black; color: white; padding: 5px; margin-right: 10px; text-align: center;"> MAIL CLAIMS TO </div> <div> DELTA DENTAL PO BOX 9085 FARMINGTON HILLS, MI 48333-9085 </div> </div>																													
OTHER COVERAGE		PATIENT INFORMATION																											
2. OTHER DENTAL OR MEDICAL COVERAGE? <input type="checkbox"/> NO IF NO, SKIP TO #11 <input type="checkbox"/> YES		12. DATE OF BIRTH 13. GENDER <input type="checkbox"/> M <input type="checkbox"/> F 14. SUBSCRIBER ID (SSN OR ID#)																											
3. AMOUNT OF PRIMARY PAYMENT \$		15. PLAN/GROUP NUMBER 16. EMPLOYER NAME																											
4. SUBSCRIBER NAME (LAST, FIRST, MIDDLE INITIAL), ADDRESS, CITY, STATE, ZIP																													
5. DATE OF BIRTH 6. GENDER <input type="checkbox"/> M <input type="checkbox"/> F 7. SUBSCRIBER/POLICYHOLDER ID (SSN OR ID#)		17. PATIENT NAME (LAST, FIRST, MIDDLE INITIAL)																											
8. PLAN/GROUP NUMBER 9. RELATIONSHIP TO PATIENT <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER		18. RELATIONSHIP TO SUBSCRIBER <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER 19. DATE OF BIRTH 20. GENDER <input type="checkbox"/> M <input type="checkbox"/> F																											
10. OTHER INSURANCE COMPANY/DENTAL BENEFIT PLAN NAME		21. IF PATIENT IS A DEPENDENT OVER AGE 19, PLEASE INDICATE STATUS <input type="checkbox"/> FULL TIME STUDENT <input type="checkbox"/> TOTALLY & PERM DISABLED <input type="checkbox"/> IRS DEPENDENT <input type="checkbox"/> SPONSORED DEPENDENT																											
DENTAL SERVICES																													
22. DATE OF SERVICE MM/DD/CCYY		23. AREA OF ORAL CAVITY		24. TOOTH NO. OR LETTER		25. TOOTH SURFACE		26. CURRENT CDT PROCEDURE CODE		27. DESCRIPTION										28. FEE									
1																													
2																													
3																													
4																													
5																													
6																													
7																													
8																													
9																													
10																													
MISSING TEETH		PERMANENT																PRIMARY										29. TOTAL FEE CHARGED	
30. PLACE X ON MISSING TOOTH NUMBERS		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J		
		32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K		
REMARKS																													
31.																													
AUTHORIZATIONS														ADDITIONAL CLAIM INFORMATION															
32. AS PERMITTED UNDER LAW, I CONSENT TO THE USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR PURPOSES OF PAYMENT OF THIS CLAIM. PATIENT/GUARDIAN SIGNATURE _____ DATE _____														34. PLACE OF TREATMENT <input type="checkbox"/> DENTAL OFFICE <input type="checkbox"/> HOSPITAL <input type="checkbox"/> ECF <input type="checkbox"/> OTHER															
33. IF PERMITTED, I HEREBY ASSIGN AND AUTHORIZE PAYMENT OF THE DENTAL BENEFITS OTHERWISE PAYABLE TO ME TO THE TREATING DENTIST. SUBSCRIBER SIGNATURE _____ DATE _____														35. NUMBER OF ENCLOSURES RADIOGRAPHS _____ DIGITAL IMAGES _____ MODELS _____															
														36. IS TREATMENT RELATED TO ORTHODONTICS? <input type="checkbox"/> NO <input type="checkbox"/> YES DATE APPLIANCE PLACED _____ MONTHS OF TREATMENT REMAINING _____															
														37. TREATMENT RESULTING FROM: <input type="checkbox"/> OCCUPATIONAL ILLNESS/INJURY <input type="checkbox"/> AUTO ACCIDENT <input type="checkbox"/> OTHER ACCIDENT															
														38. REPLACEMENT OF PROSTHESES? <input type="checkbox"/> YES DATE PRIOR PLACEMENT _____ <input type="checkbox"/> NO															
BILLING DENTIST/DENTAL ENTITY (F40 - F43: USE FOR GROUP PRACTICE/MULTIPLE LOCATIONS)														TREATING DENTIST AND LOCATION															
39. NAME, ADDRESS, CITY, STATE, ZIP														44. I HEREBY CERTIFY THAT I HAVE PERFORMED THE PROCEDURES AS INDICATED BY DATE AND/OR WISH TO OBTAIN A PRE-TREATMENT ESTIMATE FOR THE PROCEDURES WHICH ARE NOT DATED. THE PROCEDURES WERE/ARE NECESSARY IN MY PROFESSIONAL JUDGMENT. <input checked="" type="checkbox"/> SIGNED (TREATING DENTIST) _____ DATE _____															
40. NPI				41. LICENSE NUMBER				42. TIN						45. NPI				46. LICENSE NUMBER				47. TIN							
43. PHONE NUMBER														48. ADDRESS, CITY, STATE, ZIP (IF DIFFERENT THAN #39)															
49. PHONE NUMBER ()														50. ADDITIONAL DENTIST ID 51. SPECIALTY CODE															

FRAUD WARNINGS

Please read the warning statement for the state where you reside and for the state where your policy was issued.

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arizona: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Arkansas: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

California: For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

Delaware: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Idaho: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

Indiana: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Kansas: NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Louisiana: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance (Footnote 1) is guilty of a crime and may be subject to fines and confinement in prison.

Maine: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Massachusetts: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in

an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in R.S.A. 638:20.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed \$5000 and the stated value of the claim for each such violation.

Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive and insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Oregon: Any person who knowingly presents a false statement of claim for insurance may be guilty of a criminal offense and subject to penalties under state law.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Rhode Island: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Tennessee: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Texas: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Vermont: No person shall, with intent to defraud, present or cause to be presented a claim for payment or benefit, pursuant to any insurance policy, that contains false representations as to any material fact or which conceals a material fact. Any person who knowingly presents a false statement of claim for insurance may be guilty of a criminal offense and subject to penalties under state law.

Virginia: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Washington: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.



Dental Care Cost Estimator

Cost matters, and the ability to easily compare prices for different services and products has become second nature to most Americans. Delta Dental has an enhanced tool to help people find the best prices on the dental care they need to maintain good oral health.



Our Dental Care Cost Estimator is an easy-to-use tool that provides estimated cost ranges on common dental care needs for local dentists. Subscribers can compare costs for nearly 60 of the top reasons people visit the dentist. From a cleaning and an X-ray, to a crown or a root canal, the tool lets subscribers search by ZIP code and dentist to find the best price by procedure. Currently, the tool provides the total cost of the procedure; however, in the near future it will also show Delta Dental subscribers their actual out-of-pocket costs.

Access the tool

The Dental Care Cost Estimator can be accessed through our free mobile app and online.

The Delta Dental Mobile App is optimized for iOS (Apple) and Android devices. To download our app on a device, visit the App Store (Apple) or Google Play (Android) and search for Delta Dental. Or, scan the QR code at right. After logging in, click on the "cost estimator" feature to access the tool. Delta Dental subscribers will need to log in with the username and password used to access www.deltadental.com. Registration is available within the app, along with password recovery.



SCAN TO
DOWNLOAD APP

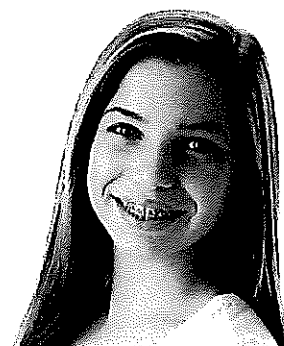
Desktop versions of the tool for both subscribers and the general public can be found on our websites.



Michigan
Ohio
Indiana

www.deltadentalmi.com/cost
www.deltadentaloh.com/cost
www.deltadentalin.com/cost

The public version of the tool does not require the user to register or log in, but only provides a range of estimated charges for out-of-network dentists. The ability to choose a particular dentist or to see in-network costs requires the subscriber to log in. Easy-to-follow instructions are available on our websites.



How Delta Dental Pays for Orthodontic Services

Proper tooth alignment is important not only for a beautiful smile, but also for function. When teeth are aligned, it's easier to chew and talk. And it's also important to correct and guide tooth and jaw development as a child grows, in order to ensure a healthy and functioning smile for adulthood.

Orthodontic services, often referred to as "ortho," are services, treatment and procedures used to correct malposed or misaligned teeth. These services can include braces, retainers and other orthodontic appliances. Your coverage level for orthodontic services depends on the plan chosen by your employer/organization. Orthodontic services are usually payable for eligible people up to age 19, and limited to the lifetime maximum per person as specified in your Summary of Dental Plan Benefits.

Do I need a referral to visit an orthodontist?

No referral is necessary if you go to an orthodontist. Both general dentists and orthodontists provide orthodontic treatment. You are free to visit the dentist of your choice. You can find a participating Delta Dental orthodontist on our websites.

You can also get this information by calling our customer service department at 800-524-0149 or by registering and logging in to Delta Dental's Consumer Toolkit® from our websites.

How will orthodontic services be paid?

Delta Dental requires your dentist to submit an orthodontic treatment plan to us. When orthodontic treatment starts, we will pay a percentage of the total fee. We will continue to make payments based on the type of treatment (18 months for comprehensive, 10 months for interceptive and 8 months for limited) or until the lifetime orthodontic maximum is reached. Payments will be made either quarterly or monthly, depending on the dental plan chosen by your employer.

What if treatment has already begun under a different carrier?

For treatment that began prior to eligibility with Delta Dental, we will make payments only for the months of treatment while eligibility is active with Delta Dental. We will calculate our payments based on the original claim form from the provider. We subtract the initial/banding fee from the total fee (as this was incurred prior to eligibility with Delta Dental) and divide by the standard number of payment months. We will then pay for the remaining payment months or until the lifetime orthodontic maximum is reached. If a group has the orthodontic maximums carried over from a prior carrier, Delta Dental will pay for only the remainder of the lifetime orthodontic maximum.

How can I find out what's covered under my plan?

To find out what's covered under the dental plan chosen by your employer:

- Refer to your Summary of Dental Plan Benefits and your Dental Care Certificate
- Register and log in to Delta Dental's Consumer Toolkit from our websites
- Call Delta Dental's customer service department at 800-524-0149



How Delta Dental coordinates benefits

Coordination of Benefits (COB) is a procedure for paying health care expenses when people are covered by more than one plan (such as a husband and wife who both have health care coverage through their respective employers). The goal of COB is to make sure the combined payments of the plans does not exceed the amount of your actual bills.

How does Delta Dental decide which plan pays as primary?

Delta Dental follows rules established by state law to decide which plan pays first (primary) and how much the other plan must pay. Refer to your Dental Care Certificate for further details on your state's rules to determine which plan pays as primary.

How does Delta Dental pay as the primary plan?

When Delta Dental is the primary plan, we pay the full benefit allowed by your contract as if you had no other coverage.

What is standard COB?

Standard COB is when the secondary plan payment is based on the balance left after the primary has paid, but does not exceed the amount it would have paid as primary or the total amount of the claim. For example, Bob and Sarah Johnson both have dental coverage. Due to their state's law, Bob's plan pays as primary and Sarah's plan pays as secondary. Bob had a cleaning on his last visit to the dentist. Standard COB is as follows:

Procedure:	Sample allowed amount:	Bob's plan is primary— pays 80 percent:	Sarah's plan is secondary— pays remainder:
Cleaning	\$100	\$80	\$20

Because Bob's plan is primary, his plan pays first and Sarah's plan pays as secondary or second. Bob's plan pays \$80 (80 percent of \$100) and Sarah's plan pays the remainder, or \$20 (does not exceed amount we would have paid as primary).

What is carve-out COB?

The carve-out (or non-duplication) method of coordinating benefits can be selected by your group as an alternative to standard COB for members who are covered under more than one dental plan. With carve-out COB if you or a member of your family have another dental plan and that plan is primary to your employer's dental plan (in other words, it pays first), our payment for covered services will equal the amount payable under your employer's dental plan **minus the amount paid by the other dental plan.**



For example: Bob Johnson, husband of ABC Products member Sarah Johnson, had a crown on his last visit to the dentist. Both his dental plan and Sarah's plan cover major restorative services like crowns at 50 percent:

Procedure:	Sample allowed amount:	Bob's plan pays 50 percent:	Sarah's plan pays 50 percent:
Crown	\$705	\$352.50	\$0

Because Bob's dental plan is primary, Sarah's ABC Products plan pays nothing because the amount payable under her plan (50 percent of \$705, or \$352.50) minus the amount paid by Bob's plan (\$352.50) equals zero.

Questions?

To find out what's covered under the dental plan chosen by your employer:

- Refer to your Dental Care Certificate
- Register and log onto Delta Dental's Consumer Toolkit® from our Web sites:
Michigan: www.deltadentalmi.com
Ohio: www.deltadentaloh.com
Indiana: www.deltadentalin.com
Tennessee: www.deltadentaltn.com
- Call Delta Dental's customer service department at:
Michigan, Ohio and Indiana: (800) 524-0149
Tennessee: (800) 223-3104

